

Editorial

'A Farewell to Arms' – but the struggle continues

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We began this editorial in May, a month when former members of the armed forces of many nations gather on the beaches of Dunkerque in France to commemorate the men and women who died there in 1940. As the German forces advanced, the Allied forces retreated; over 300,000 were evacuated by sea in every boat and ship that could be found, leaving behind thousands who were either wounded or dead. A few weeks later, veterans gathered again on the beaches of Normandy to commemorate a second battle which took place there in 1944. On 6 June, Allied forces mounted a huge seaborne invasion of Europe, backed up by heavy aerial bombardment. These D-Day landings proved a decisive point in what had become a lengthy war but success, as Spielberg depicted in the first 40 minutes of *Saving Private Ryan*, came at huge personal cost.

Dunkerque and D-Day were terrible experiences, and every year those who can, make the journey back, wearing their medals, to mark the anniversaries of these battles. Those far too young to know much about that war may wonder why they bother; they are old, can they not let it go, move on? No, they can't and neither should we. Going back is important for several reasons. First, veterans who have never had the chance to go back to the scene of a battle may never quite believe that it is over. Going back helps those who do so, to see not only that a particular battle is indeed over but also that the recovery has taken place. Dunkerque is now a thriving town of some 70,000 people; an interesting place to visit for a weekend break. Further along the Normandy beaches, little towns like Arromanches too have been transformed back into the peaceful seaside havens they were before.

A second reason for going back is the issue of survivor guilt, a state that is part of grief and post-traumatic stress, in which individuals who have faced severe danger, wonder why they and not their com-

rades remained alive. Military training, then as now, emphasises the importance of being individually and collectively able to do what is required. The training and socialisation of recruits are designed to foster interdependence so that each individual is completely confident of being able to depend on other members of the team, just as they depend on him/her. They act for each other as much as for the demands of their job (Goffman, 1968; Hennessey, 2009). Such bonds are meant to last a professional, if not a whole, lifetime; the gatherings on Normandy beaches suggest that they do so.

A third reason for going back is that talking about experiences of battle and trauma can be difficult (Herman, 2001). Little (2014) recalls a conversation with another war reporter who said that he 'couldn't have a conversation with anyone about Iraq who hadn't been there. I told him I couldn't have a conversation with anyone who hadn't been there about anything at all'. Going back provides an opportunity to meet up with those who shared the same experiences. It provides a space in which no one has to start at the beginning, and may bring both comfort and some peace of mind. Eric Lomax (1995) was a prisoner of war who was tortured and forced to work on the Burma railway. He suffered years of psychological problems as a result; returning to meet with one of his tormentors required considerable courage but it enabled him to achieve some degree of resolution.

Those who remember the Second World War are very old now; too frail, in many instances, to make the journey to any more commemoration ceremonies. Perhaps some of those who saluted their former comrades at Dunkerque and D-Day beaches this year may have wondered whether it was all worth it – the slaughter, the fear, the lives lost in a war that dragged on until 1945. It was certainly worth defeating Hitler. One of his fundamental beliefs was that there

were categories of humans; Aryans were superior to everyone else and had to be preserved in as pure a form as possible to ensure that the Thousand Year Reich would become a reality. Aryans were principally Germans but could also include other northern Europeans with German ancestry. All other humans were disposable ‘chaff’ (Hitler’s word), subhumans; interbreeding with ‘chaff’ became a crime in Nazi Germany because it weakened the pure Aryan bloodline. Subhumans included not only Jews, but members of many other groups; anyone with a disability, black people, Roma, eastern Europeans and anyone who opposed Hitler. His ideas were not new. Galton pioneered the field of eugenics as a result of his work on heredity, arguing that certain inherited characteristics in humans might be more desirable than others. His ideas were taken up with considerable enthusiasm in Europe and the US, and led to compulsory sterilisation of those deemed unfit to have children because, for example, they had a disability, were gay or promiscuous, Roma, black or just poor. Others were killed in euthanasia programmes. Hitler and his followers implemented eugenicist ideas and solutions to the problem of what to do with people who did not meet society’s norms, and they did so with great efficiency, on an industrial scale.

Defeating Hitler was, therefore, worth the effort, but the notion of categories of humans persists in all societies today; we call it ‘inequality’ now but it amounts to the same thing. The more we learn about differences between us, the more categories we have to choose from, but the fact remains that, throughout the world, some human beings are deemed less worthy, less valuable than others because of some characteristic that is perceived to separate ‘them’ from ‘us’ and which incurs stigma, suffering, violence, discrimination and death. This distinction is evident in the hatred directed towards women who are denied the most basic human rights, trafficked, denigrated, raped and murdered either as acts of war or because, even in peace time, men know that they will not be punished for their actions (Black, 2009; McGee and Johnson, 2012; McGee, 2013). It is evident in the continued destruction of children who are trafficked for sex, recruited into armies and denied food and education (UNICEF www.unicef.org/protection/57929_58005.html; UNICEF, 2006). It is evident in the hatred and violence meted out to those whose skin colour, religious beliefs, sexuality, lack of physical and/or intellectual ability, poverty or simple difference mean they do not fit into some local norm. These are dramatic examples, though we make no apology for raising them, but the behaviours they involve are played out equally well in the minutiae of daily life: excluding, bullying, stigmatising, making fun of, sneering, tormenting and many other behaviours. ‘You are a girl and must cover your mouth when you smile’; ‘He is a

Shia/Sunni, what can you expect?’, ‘They are immigrants, they do not matter’. The notion of ‘othering’, of ‘them’ and ‘us’ is, therefore, deeply ingrained and the language used to justify inequality often sounds, at least superficially, quite reasonable and, by implication, justifiable. The ‘other’ is not like ‘us’. We can treat him/her differently and withhold what we smugly regard as ‘our’ entitlements because ‘they’ are not ‘one of us’. As we have noted elsewhere, we do this ultimately because we can and because we can get away with it (Black, 2009; McGee and Johnson, 2008). Schutte’s (1995) study of racism in the apartheid era of South Africa and Arendt (1963) in her book about Eichman’s trial in 1961 have shown us just how easy it is, particularly when ‘othering’ and the resulting inequalities are sanctioned by the society in which we live. We do not have to think about it, we simply do it.

In our ten years as editors of this journal we have attempted to challenge ‘othering’ and inequalities by providing a space in which they are critically examined. We are grateful to Andrew Bax at Radcliffe Medical Publishing, as it was then known, for his vision in recognising the need for a journal such as this, for his commitment and for his unfailing support. We also thank Andrea Hargreaves, the Production Editor at that time, for her guidance and encouragement throughout our first few years. Producing and editing this journal has not been an easy job. Tackling inequalities is not sexy; it does not attract much money or investment. On the whole, people do not welcome the exposure of social injustice; they would rather it remained hidden and wrap their excuses for keeping it so in terms of ‘cost’. Our present publishers have advised us that they wish to stop producing the journal, on the basis of a new commercial assessment. They and we are seeking a new home for the journal. We are, therefore, grateful to the many writers and reviewers, from quite disparate fields, who have worked with us and with whom we have developed long-term working relationships. It has been a privilege to work with you and we hope that you will continue to carry the torch. Finally we thank the members of our editorial board whose expertise and commitment has sustained us throughout our ten years. We wish you all well and we hope that you will join us again if we are successful in finding another publisher to keep this title alive and to maintain the evidence base for diversity and equality. If not, we shall borrow the catchphrase of another European conflict: ‘a luta continua’ – the struggle continues.

IN THIS ISSUE

We begin with an unusual contribution to our guest editorial series. To date this journal has not considered the role of technology or the commercial sector in the

struggle against inequality. We are, therefore, pleased to present this editorial from Gisela Abbam at GE Healthcare which, significantly perhaps, is listed on its own website as a 'certified women-owned international company'. She presents a strong argument in favour of technological progress as a tool to reduce inequality on a global scale. Role models, and engagement, are also important, and it is worth noting that minorities and inequalities provide significant commercial opportunities that may offer some competitive advantages.

Our first research paper focuses on an aspect of inequality that has been previously addressed from varying perspectives, namely the experiences of health and care professionals who have migrated after qualifying in their chosen fields. Simpson and Ramsay's paper presents an analysis of the narratives of overseas-born doctors who came to support the UK's NHS and who are now, in many cases, retiring after a lifetime of struggle (Simpson and Ramsay, 2014). This is essentially a tale of learned resilience and a depressing reflection that, while the labels may change, discrimination and intolerance continue despite efforts and numerous initiatives to bring about change. What is of particular interest here is the application of Albert Memmi's ideas about '*heterophobia*' which provides a novel approach. This paper is also a useful contribution to the emerging realisation of the complexity of discriminations, and the way that 'Intersectionality' works. It also complements four papers which appeared in earlier issues of this journal, regarding overseas-born nurses (Allan *et al*, 2004; Matiti and Taylor 2005; Taylor, 2005; Likupe *et al*, 2014).

Our next two papers highlight the need for cultural competence in practice settings and the importance of adapting both care delivery and information about health. Manning *et al* (2014) present a review of patients admitted to the Leicester Stroke Unit, and the factors affecting their carers after discharge. The review identified significant clinical differences between the needs of members of minority groups and the majority population and highlighted the need to do 'the same things differently', requiring cultural competence at both individual and institutional levels. A similar message emerges from our next paper which reports on a participatory approach to information delivery for those with long-term conditions such as COPD (Shum *et al*, 2014) and demonstrates the effects of one way of working with families and hence, carers (Poureslami *et al*, 2012). We believe that the lessons are highly transferable both between continents, and across disease groups.

Our fourth paper concerns the experiences of Saudi people living with HIV in Saudi Arabia (Omer *et al*, 2014). We have highlighted this paper as our 'open access' free to read access paper in this issue, because of its significance as a contribution to an under-debated

issue – the way in which people deal with a stigmatised disease in a Muslim country. It is, like the previous papers, a study of coping behaviours and the role of culture in disease management, but additionally, from a European or North American perspective, provides a reminder of the way things once were here too, as well as a remarkable testimony to the researchers' ability to inspire confidence in their informants.

Our next paper is a systematic review which adds to the perspective on self-management and long-term conditions (Sidhu *et al*, 2014). Somewhat counter-intuitively, they cannot conclude that cultural adaptation is necessarily associated with better clinical outcomes, but this may be, as they suggest, due to poor design or reportage of such studies and interventions. They do make it clear that when things are culturally adapted, it is important to remember that migrants and minorities will also adapt and borrow from majority cultures, especially in relation to diet. We have provided the detailed tabulations associated with any good systematic review as an online appendix, to reduce our environmental impact and page-length.

Our next three papers focus on practice issues. First, Markham *et al* (2014) once more demonstrate the potential of Leicester as a laboratory for innovative practice development, exploring the barriers to use and perceptions of hospice care among minority groups in the city. Information that is appropriate, and reassuring that cultural needs are taken into account, has a key role to play in ensuring that services that are available, are used. If you don't understand the menu (readers who have visited 'exotic' or minority-ethnic restaurants of a tradition different from their own will understand), you cannot make the best choices. Next, Quickfall (2014) explores the development of cultural competence among Scottish nurses dealing with refugees and asylum seekers. We are particularly pleased to include this paper as the initial stage of this work was published in our first ever issue (Quickfall 2004). In this current paper, Quickfall applies her model of cultural competence to community settings and examines the preparedness of nurses to provide care for refugees and asylum-seeking migrants. Finally, there is a good news story about the attitudes of staff to diversity initiatives in a US Navy hospital (Gaze and Oetjen, 2014). In many respects, race relations and equality/diversity initiatives can be said to have originated with the US Military, when it was found that training was needed to ensure discipline and efficiency in a multi-racial volunteer-staffed army after the Second World War (Katz and Ivey, 1977). One of the major problems at the time was convincing the white majority of their responsibilities towards inequality: no-one really asked the rest of the population what they thought about diversity initiatives. Gaze and Oetjen demonstrate the continuing salience

of this issue and the increasing diversity of both the US civilian and military populations. They provide some instructive insights into the management of diversity initiatives which forms a fitting conclusion to this review of issues arising from and since the events of the 1940s with which we opened this editorial.

We conclude this volume, as every previous one, with a selection of materials for continuing professional development and awareness raising, including our Practitioner's Blog, a CPD feature on airways disease (COPD), which is significantly under-researched in relation to minority groups and equality; two sideways looks at articles you might have missed in Did You See?, and the usual roundup of resources and reviews in our Knowledgeshare section. In connection with that, we commend our readers to a new resource. The Royal College of Nursing of the UK has recently launched its Knowledge and Innovation Action Plan for 2014–2018. It sets out the ways in which the RCN will use, build, assure and share knowledge over the next five years. They want to make it easier for nursing staff to use knowledge in practice and policy making and to feel confident and able to use research and innovation to enhance care. To help the nursing community and other stakeholders to know what knowledge RCN holds, and how to access or contribute to it, visit www.rcn.org.uk/knowledge. Finally, we once again thank our peer reviewers, and offer a consolidated index to the articles of this volume. We hope to be able to offer you a 12th (and subsequent) volume, to advance diversity and equality in health and care, and will see what the future holds. Look backwards, but also look forwards.

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